THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS
239 CAUSEWAY STREET, SUITE 200
BOSTON, MA 02114
800-414-0168
www.mass.gov/dph/boards

Temporary Practice Certificate Application Instructions and Checklist

Carefully read the following instructions for completing the license application. Complete applications must include the following documents:

_____ Completed application form with a passport style photo and notary signature.

_____ Official transcripts in signed sealed envelopes for all undergraduate programs/degrees, physician assistant programs/degrees and any other post-secondary programs/degrees. **Transcripts must be complete and indicate the degree and date conferred.** Transcripts may be sent directly to the Board by the institutions. Transcripts pending completion may be accompanied by a certified letter from the Registrar's Office verifying the completion of all requirements for a degree.

_____ Verification of licensure status, in signed sealed envelopes, from any state or jurisdiction in which you now or have previously held **any** professional license. Verifications may be sent directly to the Board by the state or other jurisdictions.

_____ An official **Physician Assistant Information Profile** from the Federation of State Medical Boards' ***Federation Credentials Verification Service*** may be submitted in lieu of transcripts and NCCPA documentation. For more information about the FCVS Profile, visit the FCVS web site at www.fsmb.org.

_____ Supervising Physician form if applicable. Your Temporary Practice Certificate may be issued without this form; however it must be on file with the Board within 30 days of beginning employment. A MA Board of Registration in Medicine Physician Profile must be attached. Profiles are available on line at www.massmedboard.org.

_____ Work Setting Information form, if applicable. Your Temporary Practice Certificate may be issued without this form; however, it must be on file with the Board within 30 days of beginning employment.

NOTE: Multiple supervising physicians and work settings require submission of separate forms for each supervising physician and each work setting.

_____ Check or money order payable to the Commonwealth of Massachusetts for $102.00. Cash or foreign currency is not accepted. NOTE: When you apply for a full license, you will be required to pay an additional application and license fee of $151.00.

_____ Retain a copy of the completed application for license for your records. Employers may require that you provide them with a copy.

PLEASE NOTE:

In order to apply for a license, you must submit verification from NCCPA that you have passed the certification examination. This must be in hard copy format; email verifications are not acceptable. A form to request that NCCPA send the verification is included in the application packet. In the event that you fail the certification examination a temporary practice certificate

may be extended by submitting a new written certification stating that you have registered to retake the written examination on a date not more than two years from the date of graduation from physician assistant training. Your temporary practice certificate shall remain valid until the results of the re-examination are published. If you fail to pass a second time, you must cease practicing immediately.

Pursuant to 263 CMR 3.04 (4), Board regulations state that a physician assistant applicant/ registrant must notify the Board in writing of any of the following events within 30 days of their occurrence: change of address of applicant/registrant; change of identity of the applicant/registrant's employer or employment status of the applicant/registrant; any change in the identity or address of the registered physician supervising the practice of the applicant/registrant; or, the permanent departure of the applicant/registrant from the Commonwealth of Massachusetts. *Failure to update your address may result in failure to receive a license renewal application and a lapse in your license.*

The address printed on your license is a PUBLIC RECORD that is freely available to any member of the public who calls the Board. If you are using your home address, you may wish to consider changing this to an office address. Address changes may be done on online at the board's website www.mass.gov/dph/boards/ap or you may obtain a form online to submit to the Board's office. Please be advised that address changes can take 4-6 weeks to be processed.

Answers to many questions may be found on the Board's website. Statutes and regulations governing physician assistant licensure and practice may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168.

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All Questions Must be Completed

Temporary Practice Certificate Fee - $102.00

1. Applicant Name :_____
(Last) (First) (Middle)
a. Maiden Name/Other Name (if applicable):

_____
(Last) (First) (Middle)

2. Address: _____
(No.) (Street) (Apt. #)

_____
(City/Town) (State) (Zip Code)

3. Most Recent Previous Address:

_____

_____
(City/Town) (State) (Zip Code)

4. Telephone Number(s) Day:_____ Evening:_____

5. Date of Birth: ____/____/____ 7. Place of Birth: _____
(mm/dd/yyyy)

8. Gender: M F 9. Height: _____ 10. Weight: _____ 11. Eye Color: _____
(Circle One)

12. Mother's Maiden Name: _____

13 . Social Security Number (**Disclosure is mandatory**): _____-_____-_____
Pursuant to G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax and child support laws of the Commonwealth.

FOR BOARD USE ONLY
Cash Number: _____ Temporary Certificate Number: _____

14. I certify, under the pains and penalty of perjury, that I have taken, or I will register for and take the next available administration of the NCCPA certifying examination.

Scheduled date of NCCPA Certification exam _____/_____
(mm/yyyy)

Signature: _____ Date: _____

Applicant must arrange for official written documentation of certification to be sent directly to the Board by NCCPA. (Request Form Included in Application Packet)

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15. Education

PA Program Name/Location: _____
Degree awarded: _____ Date of Graduation:___/_____
(mm/yyyy)
Submit official transcript in signed sealed envelope. Transcripts may be mailed directly to the Board by the Institution.

Bachelor's Degree School Name/Location: _____
_____

Degree: _____ Date Awarded: _____/_____
(mm/yyyy)
Submit official transcript in signed sealed envelope. Transcripts may be mailed directly to the Board by the Institution.

Other post-secondary institution(s)/location(s): _____

Degree: _____ Date Awarded: _____/_____
(mm/yyyy)
Submit official transcripts in signed sealed envelope. Transcripts may be mailed directly to the Board by the Institution.

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16. List **all** professional licenses or certifications currently or previously held in any other states or jurisdictions.
Submit a certificate of standing from each state or jurisdiction in a signed & sealed envelope.
Certifications may be mailed directly to the Board by the state or jurisdiction.

Lic. No.	Profession	Issuing Jurisdiction
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you answer YES to any of the following questions attach a separate sheet explaining each one.

17. Have you ever been a defendant in a Medical Malpractice claim?
Yes _____ No_____
Include claim number, date(s) and current status of claim with your explanation.

18. Have you ever applied for and been denied any professional license in the United States or any country or foreign jurisdiction?
Yes_____ No_____

19. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?
Yes_____No_____

20. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?
Yes _____No_____

21. Have you ever voluntarily surrendered any professional license to a licensing or certification board in the United States or any country or foreign jurisdiction?
Yes_____ No_____

22. Have you been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor traffic violations for which a fine of $100 or less was imposed.
Yes _____ No_____

AFFIDAVIT

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and physician assistant associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Physician Assistants any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Physician Assistants to release information contained in this application in association with its processing.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board (CHSB) for access to conviction and pending criminal case data. As an applicant for authorization to practice as a Physician Assistant, I understand that a criminal record check may be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information provided in this application pursuant to G.L. c. 112, ss. 23R through 23BB is correct to the best of my knowledge.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Registration of Physician Assistants to suspend or revoke a license issued to me in accordance with Massachusetts Law. I further attest that, pursuant to MGL c.119, s.51A, I will fulfill my obligations to report abuse and neglect of children; that I will comply with and conform to the ethical standards of the medical profession in Massachusetts and all rules and regulations of the Board; and that I have read and understand this affidavit. To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by law.

I agree to abide by the rules and regulations for licensing as a Physician Assistant as defined in and promulgated pursuant to M.G.L. c. 13, ss. 11C.

I attest that the statements made herein are truthful and are made under the pains and penalties of perjury.

Signature of Applicant _____**Date** _____

Attach a recent 2x2 passport style photo

Notary Name: _____

Commission expires: _____

[Seal]

Attach a non-refundable fee of $102.00 (check or Money Order) payable to the Commonwealth of Massachusetts.

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SUPERVISING PHYSICIAN FORM
For Both
Temporary Practice Certificate and License Applications

Complete this form and submit it to the Board with application for Temporary Practice Certificate or License Application. If you are not employed at the time of applicaton for a Temporary Practice Certificate or a License, return this form to the Board at the above address within 30 days of beginning employment in the Commonwealth of Massachusetts. If you have more than one supervising physician and work setting, you must complete and submit a separate form for each supervising physician and each work setting.

Applicant/PA Name: _____
(Last) (First) (Middle) (License/Temp Practice #)

Address: _____
(No.) (Street) (City/Town) (State) (Zip Code)

Date of Employment: _____

Physican Name: _____
(Last) (First) (Middle) (License #) (Speciality)

TO BE COMPLETED BY SUPERVISING PHYSICIAN:

A licensed physician can be the Supervising Physician of Record for no more than **two (2**) Physician Assistants at any one time [M.G.L., C 112, Sec 9E and 263 CMR 5.05 (2)]. List all physician assistants currently under your supervision:

Name: _____ Lic Number: _____

Name: _____ Lic Number: _____

If you answer YES to any of the questions below, please submit a separate sheet with a detailed explanation.

Have you [the supervising physician] been disciplined [as defined by the Board of Registration in Medicine regulations] by any government authority, hospital or health care facility or professional medical association [international, national or local] within the past ten years from the date of this application?

_____Yes _____ No

Within the last ten years form the date of this application, have you ever had staff privileges, employment or appointment in a hosptial or health care institution denied, suspended or revoked?

_____ Yes _____ No

Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?

_____ Yes _____ No

I understand that, notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be in conformance with Board regulations at 263 CMR 5.04 and 5.05.

_____ _____
Signature of Supervising Physician Date

A MA Board of Registration in Medicine Physician Profile must be attached. Profiles are available on line at www.massmedboard.org. Send the profile and the completed form to the MA Board of Physician Assistants at the address above.

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WORK SETTING INFORMATION
For Both
Temporary Practice Certificate and
License Applications

Complete a separate copy of this form for each work setting in which you are employed as a physician assistant.

If you are not employed at the time of application return this completed form to the Board of Registration of Physician Assistants, 239 Causeway Street, Boston, MA 02114 within 30 days of commencing employment.

Applicant Name:

_____
(Last) (First) (Middle) (License/Temp Practice #)

Name of Facility or Office: _____

Address: _____
(No.) (Street) (City/Town) (State) (Zip Code)

Effective Date: _____

Type Facility: Office ( ) Clinic ( ) HMO ( ) Hospital ( ) Other: _____

Type Employment: Full time ( ) Part time ( )

List names of Massachusetts's health care facilities (including group practices) at which you will practice or be affiliated with in this work setting:

_____
_____
_____

Check all areas of practice that apply to this setting:

___ Primary Care	___ Administration	___ Emergency Medicine
___ General Surgery	___ Internal Medicine	___ Occupational Health
___ Geriatric Medicine	___ Education	___ Clinical Research
___ Obstetrics/Gyn.	___ Pediatrics/Adolesc.	___ Orthopedics
___ Oncology	___ Dermatology	___ Cardiology
___ General Surgery	___ Surgical Specialty _____	
___ Education	___ Medical Specialty _____	
___ Other _____		

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NCCPA CERTIFICATION REQUEST FORM

Complete this form and mail it to:

NCCPA
12000 Findley Road, Suite 200
Duluth, GA 30097-1409

Retain a copy for your records.

I hereby authorize and direct the National Commission on Certification of Physician Assistants, Inc., to release to the

Massachusetts Board of Registration of Physician Assistants
239 Causeway Street, Suite 200
Boston MA 02114

any and all information concerning my eligibility, examination, and/or certification status, and/or examination scores which the Massachusetts Board of Registration of Physician Assistants may require in conjunction with my application for registration. I hereby release the National Council on Certification of Physician Assistants, Inc., and its agents and employees from any liability arising out of its compliance with such a request for information.

_____ _____
Signature of Applicant Date

1. Applicant Name:
   _____
   LAST FIRST MIDDLE
2. Maiden Name/Other Name: _____
   LAST FIRST MIDDLE
3. Address: _____
   NO. STREET APT. #
   _____
   CITY/TOWN STATE ZIP
4. Day Telephone Number:_____ 5. Date of Birth: ___/__/____
   (mm/dd/yyyy)
6. Social Security Number: _____
7. NCCPA Certificate No.:_____
8. Date of Exam: ____/____/____
   (mm/dd/yyyy)

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure
Board of Registration of Physician Assistants
239 Causeway Street, Suite 200, 2nd Floor, Boston, MA 02114
(617) 973-0800

Federation Credentials Verification Service
(FCVS)

FCVS was established in September 1996 to provide a centralized, uniform process for state medical boards to obtain a verified, primary source record of a physician's core medical credentials.

This service is designed to lighten the workload of credentialing staff and reduce duplication of effort by gathering, verifying and permanently storing the physician's and/or physician assistant's credentials in a central repository at the FSMB's offices.

FCVS obtains primary source verification of medical education, postgraduate training, examination history, board action history, board certification and identity. This repository of information allows a physician and/or physician assistant to establish a confidential, lifetime professional portfolio with FCVS which can be forwarded, at the physician's request, to any state medical board that has established an agreement with FCVS, hospital, health care or any other entity.

FCVS Physician Assistant

Applicants who complete the verification process establish a permanent, lifetime portfolio of primary-source verified credentials-allowing quick, easy and inexpensive access to medical credentials. These documents can be used throughout the applicant's career for state licensure, hospital privileges, employment and professional memberships.

Contact: www.fsmb.org